Appendix F. Summary of Public Input

Introduction

The Health Care Reform Coordinating Council (HCRCC) solicited public comments on the staff recommendations presented at the November 16th HCRCC meeting. Five public hearings were held across the State—in Baltimore, Frederick (Western Maryland), Hyattsville (Prince George's County), Waldorf (Southern Maryland), and Wye Mills (Eastern Shore)—in order to gain input. Close to 100 individuals, organizations, and coalitions of organizations provided public testimony at the hearings or submitted written comments via the HCRCC website. Organizations and coalitions which submitted comments are listed at the end of this document. This summary attempts to capture the essence of these comments, but it may miss some of the emphasis and nuance of the originals.

Major themes raised by commentors included the future role of brokers; the option for early expansion of Medicaid; exchange governance, structure, and functions; the role of Local Health Departments in developing state and local strategic plans; and the preservation of safety net providers. In addition, a number of commentors highlighted locality-specific issues and concerns related to health care delivery. For example, on the Eastern Shore, concerns encompassed the rural designation of provider rates, the large share of retirees, and the lack of public transit throughout the region. Commentors emphasized that these issues need to be addressed in anticipation of caseload increases as a result of the Medicaid expansion. Throughout the State it was felt that counties in rural and urban areas must have customized approaches to reform implementation.

Comments on Draft Recommendations

Recommendation #1: Establish the basic structure and governance of Maryland's Health Benefit Exchange.

Numerous commentors addressed the conceptual structure and governance of the Exchange. Views differed regarding whether the Exchange should be an independent public entity, versus a private nonprofit organization. The principals in support of a public entity included transparency and ease of collaboration with other government agencies to achieve seamlessness between Medicaid and the Exchange. Commentors in support of a private organization cited the flexibility and maneuverability needed to adjust quickly to market conditions, particularly given the unfamiliarity of the new marketplace. Commentors from both perspectives highlighted the Massachusetts, Utah, and Chesapeake Regional Information System for our Patients (CRISP) models. Numerous commentors requested that exchange governance include stakeholders outside of the public sector, such as brokers, public health academia, patient and consumer advocates, representatives of small business, and community-based health and social service organizations.

Many from the broker community raised concerns about their future role. Commentors expressed concern that exchange navigators would take up market share, reducing broker revenues, and leading to job loss for brokers. They asked that the HCRCC explore symmetry in the regulatory requirements between brokers and navigators.

There was discussion of the requirement for the exchange to become financially self-sufficient. Commentors recommended that this not give unfair advantage to the option to structure the exchange as a public entity. Commentors recommended that revenues be raised for the Exchange in a way that promotes equity among markets.

Recommendation #2: Continue development of the State's plan for seamless entry into coverage to meet federal implementation deadlines and to maximize federal funding for information technology systems and infrastructure.

Commentors emphasized the "no-wrong door" policy as a critical component for anyone seeking entry into coverage. Furthermore, they noted that it is especially important as new federal and Maryland IT systems are developed in the coming years. Numerous commentors expressed a need for the overhaul of the existing CARES system. A new system is needed to create seamless pathways between the Exchange and Medicaid, as federally required, as well as seamlessness between health coverage and other public assistance programs. Commentors recommended Maryland take full advantage of the 90-10 federal match for Medicaid eligibility system changes.

Commentors supported the "culture of insurance" concept, but emphasized this needs to incorporate private as well public insurance in a "culture of care." An association with public insurance could result in negative branding.

Suggestions for consumer friendly enrollment stations include post offices, schools, and other community-based locations. Web-based and non-web-based pathways are needed. It was suggested that efforts to conduct outreach and streamline eligibility could leverage existing data sources, such as State income tax and other data.

A number of commentors expressed support for implementing the optional Medicaid expansion prior to 2014. They noted that phasing in enrollment through early expansion affords a smoother scenario for handling caseloads and system changes.

Recommendation #3: Develop Centralized Outreach and Education Strategy.

Commentors emphasized the importance of centralized outreach and education, and noted that the various locality and cultural differences throughout Maryland necessitate specialized messages for different regions. Because of the limited funding for outreach, commentors suggested efforts begin as soon as possible to ensure initiatives are completed before the

Medicaid expansion and Exchange operation take place. Support was expressed for promoting existing programs, such as the Health Insurance Partnership for small businesses.

Recommendation #4: Develop State and Local Strategic Plans to Achieve Improved Health Outcomes.

Commentors emphasized the need to maintain the importance of safety-net programs in State and local strategic plans to promote better coordination of care. Additionally, commentors emphasized the critical role local health departments and other local partners play in the process to develop these plans. Substantive input from local entities will help adapt to local conditions.

Recommendation #5: Encourage Active Participation of Safety Net Providers in Health Reform and New Insurance Options.

There were numerous suggestions that Maryland *not* overlook the important role of safety net programs. Commentors emphasized the need to recognize and integrate the work of local health departments, community health centers, federally qualified health centers, school-based health clinics, community-based organizations, individual providers, hospitals, and others that serve as the safety net. Each provider's core services should be identified. Services must be ramped up in anticipation of new demand resulting from the Medicaid expansion, and well as continued demand from individuals who will remain uninsured. It was suggested that newly eligible individuals will first seek out care from safety net providers.

Recommendation #6: Improve Coordination of Behavioral Health and Somatic Services.

Commentors identified the need to incorporate mental health services into a more coordinated structure that includes treatment for substance abuse disorders and other medical care services. Commentors stated this is a critical step in realizing true, comprehensive care for these patients.

Recommendation #7: Incorporate strategies to promote access to high quality care for special populations.

Strategies raised for addressing barriers to care for special populations include efficient care coordination among all safety net providers and revised enrollment and eligibility systems. Another issue raised was the need to facilitate eligibility for young adults exiting the foster care system. Lastly, the importance of oral care access was mentioned for special populations, as well as Medicaid recipients, when creating these strategies.

Recommendation #8: Institute comprehensive workforce development planning.

Commentors raised the need to address workforce issues in the field of home and community-based long term care. Strategies suggested for workforce planning included increased partnership-building to use existing resources more efficiently; greater coordination to maximize

the potential to secure grant funds; the important role of health care institutions in planning; and a focus on loan forgiveness and wage equity to promote retention and recruitment.

Recommendation #9: Promote and support education and training to expand Maryland's healthcare workforce pipeline.

Commentors emphasized the inclusion of poverty competency training in the curriculum of primary care providers, to address the multi-faceted needs of low-income individuals. Additionally, commentors gave support for team approaches in addressing the increased demand for services and improving the quality of care. Although there was consensus for this approach, some commentors added that the head of this team should ultimately be a physician. Commentors expressed concern about the challenges of translating these concepts into practice within state and private entities.

Recommendation #10: Explore improvements in professional licensing and administrative policies and processes.

Commentors suggested scope of practice changes could reduce unnecessary care and referrals, allowing the patient to resolve most of their primary care medical needs in one instance, or within one institution. Others added that examination of how services are delivered is critical in assessing any changes.

Commentors noted that Maryland does not allow provisional licensure status to nurses, foreign-borne or otherwise, that do not meet the Maryland Board of Nursing criteria. Revisiting such licensure processes may affect the nursing pool in Maryland. Also, it was suggested that infrastructure support is needed.

Recommendation #11: Explore changes in Maryland's healthcare workforce liability policies.

Commentors wanted Maryland to examine and pursue the tort alternatives to medical litigation provided by the ACA. Commentors also suggested that free clinics that undergo the annual Federal Tort Claims Act deeming process on behalf of their volunteer physicians could provide immunity from medical malpractice lawsuits related to their work at the free clinic. Commentors also suggested that there not be an increase to the cap on damages in medical malpractice cases. Furthermore, they suggested that Maryland study the continued efficacy of the Maryland Health Claims arbitration system.

Recommendation #12: Achieve Cost Savings and Quality Improvements through Payment Reform and Innovations in Health Care Delivery Models.

Numerous commentors emphasized the importance of evidence-based practices in payment reforms, as well as in consideration of any scope of practice changes.

Recommendation #13: Promote Improved Access to Primary Care

Commentors noted that although the ACA increases Medicaid primary care reimbursement rates, this needs to be addressed prior to 2014. They stated that many providers in Maryland refuse to accept Medicaid patients because of the current rates, which creates barriers to access, delays needed care, and ultimately leads to the need for more expensive care.

Recommendation #14: Achieve Reduction and Elimination of Health Disparities through Exploration of Financial, Performance-based Incentives and Incorporation of Other Strategies.

Commentors suggested that cultural competency training not be limited to race and ethnicity, but also address low-income status. It was noted that low-income Marylanders come from very different urban and rural settings, and initiatives should address differences according to geography as well as race and ethnicity.

Recommendation #15: Preserve Strong Base of Employer Sponsored Insurance.

Commentors, notably brokers, expressed concern over the potential effects the exchange will have on the broker/insurance agent industry. They suggested the functions of the navigator cannot replicate the personalized customer service and quality of service rendered by brokers or insurance agents.

Recommendation #16: Ensure Continued Leadership and Oversight of Health Care Reform Implementation.

There was a broad consensus on the need for the HCRCC to continue its work. Commentors said the collaboration of the HCRCC must be replicated in the exchange governance. Commentors suggested that if the HCRCC continues, private sector stakeholders be added as members.

Commentors

In addition to private citizens, the following organizations and coalitions submitted written or oral comments:

Aist & Associates
A.W. Associates
Allied Benefits and Compensation, Inc.
American Academy of Physician Assistants
ARM International, Healthcare
Avery Hall Benefits and Solutions
Baltimore City Healthy Start
Cecil County Health Department

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Coventry Healthcare, Inc.
Cross & Wood and Associates, Inc.
DentaQuest
Edwards, Sanders and Associates, LLC
Elizabeth Cooney Care Network
Grabner Financial
Health Care for All
Health Care for the Homeless
Johns Hopkins Center for Substance Abuse Treatment and Research
Johns Hopkins School of Medicine, Division of Geriatric Medicine and Gerontology
Keller Stonebraker Insurance, Inc.
Legal Aid Bureau, Inc.
Maryland Alliance for the Poor
Maryland Association of County Health Officers
Maryland Associations of Health Underwriters
Maryland Citizens Health Initiative
Maryland Dentist Association
Maryland Department of Disabilities
Maryland Dietetic Association
Maryland Disabilities Law Center
Maryland Health Care Reform Coordinating Council, Education and Communications Working Group
Maryland Hospital Association
Maryland Nurses Association Legislation Committee
Maryland Optometric Association
Maryland State Medical Society
Maryland Women's Coalition for Health Care Reform
Maryland Women's Coalition for Health Care Reform, for Eastern Shore
Medstar Health
Montgomery County Department of Health and Human Services
Mullaney Insurance, Inc.
National Association of Health Care Executives
Nurse Practitioner Association of Maryland
Pioneer Insurance Agency, Inc.
Prince George's County Department of Health
Progressive Chevely-Nonpartisan Community
Rural Maryland Council
RWO Insurance
St. Mary's Hospital
The Alliance for Integrative Health Care
University of Maryland School of Social Work
Voices for Quality Care
Welfare Advocates
What A Stitch, LLC